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Issue Date: 12 May 2003

Case No. 2002-BLA-00441

In the Matter of
Theodore B. Barker,
Claimant,

v.

Westmoreland Coal Company and
Acordia Employer's Service,
Employer/Carrier,

and

Director, Office of Workers' Compensation Programs
Party-in-Interest.

Appearances:

Ron Carson, Benefits Counselor
For the Claimant

Douglas Smoot, Esq.
For the Employer

Before: Linda S. Chapman
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. Section 901 et seq. In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensation Programs, for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally disabled at the time of their deaths (for claims filed prior to January 1, 1982), or to the survivors

of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising form coal mine employment and is commonly known as "black lung".

A formal hearing was held before the undersigned on February 5, 2003 in Abingdon, Virginia at which all parties were afforded the opportunity in accordance with the Rules of Practice and Procedure (29 C.F.R. Part 18) to present evidence and argument as provided in the Act and regulations issued thereunder, set forth at Title 29, Code of Federal Regulations, Parts 410, 718, 725, and 727. The Employer's brief was filed on March 18, 2003; Claimant, through his representative, opted to present closing argument at the hearing. The Director did not file a brief.

I have based my analysis on the entire record, including the exhibits and representations of the parties, and have given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.

JURISDICTION AND PROCEDURAL HISTORY

The Claimant, Theodore B. Barker, filed a claim for benefits on July 15, 1999 (DX 2). The District Director awarded benefits on March 29, 2000, based on a finding of complicated pneumoconiosis (DX 29). Employer requested a hearing, and following a hearing, Administrative Law Judge Daniel Solomon issued a Decision and Order Denying Benefits on October 18, 2000 (DX 48). Claimant then appealed to the Benefits Review Board (Board), which issued a Decision and Order on October 23, 2001, affirming Judge Solomon's denial of benefits (DX 53).

Claimant submitted new evidence in support of modification on June 19, 2002 (DX 55). The District Director issued a Proposed Decision and Order Denying Request for Modification on July 19, 2002 (DX 56) and Claimant requested a hearing.

The Claimant filed an earlier claim on March 8, 1978, which was finally denied by the Benefits Review Board on August 29, 1996. In that claim, Administrative Law Judge Julius Johnson issued a Decision and Order on a request for modification on September 15, 1995, finding that the x-ray evidence was sufficient to establish the presence of pneumoconiosis and, thus, invocation of the interim presumption under Section 727.203(a)(1), but also that the evidence of record was sufficient to rebut the interim presumption under Section 727.203(b)(3).

ISSUES

The issues in this case are:

1. Whether the Claimant has pneumoconiosis;

2. Whether the Claimant is totally disabled due to pneumoconiosis; and

3. Whether the evidence establishes a mistake in fact or change in conditions which warrants modification pursuant to Section 725.310.

(DX 62, Tr. 11).

APPLICABLE STANDARD

Claimant's request for modification is governed by Section 725.310 of the regulations, which provides that any party may request modification if such request is filed within one year of the determination. Under Section 725.310(a), the terms of the award or denial of benefits can be reconsidered if the party asking for modification can establish a change in conditions or mistake in determination of fact.

In evaluating a modification request based on an alleged change in conditions, an administrative law judge is required to undertake a *de novo* consideration of the issue by first independently assessing the newly submitted evidence to determine whether it is sufficient to establish the requisite change in conditions. If a change is established, the administrative law judge must then consider all of the evidence of record to determine whether the claimant has established entitlement to benefits on the merits of the claim. *Kovac v. BNCR Mining Corp.*, 14 B.L.R. 1-156 (1990, *modified on reconsideration*, 16 B.L.R. 1-71 (1992).[1] *See also, Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993) and *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-8 (1994). In *Kingery*, the Board, citing its decisions in *Kovac* and *Nataloni*, described the proper scope of the *de novo* review of a modification request as follows:

> [A]n administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

Id. at 11.

The Board has also held that the Administrative Law Judge should always review the record on modification to assess whether a mistake of fact has occurred. In determining whether a mistake of fact has occurred, the Administrative Law Judge has broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted. *Jessee v. Director, OWCP*, 5 F.3d 723 (4th

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[1] In its decision on reconsideration, the Board modified its holding in *Kovac* by stating that new evidence is not a prerequisite to a modification based on an alleged mistake in a determination of fact; rather, "[m]istakes of fact may be corrected whether demonstrated by new evidence, cumulative evidence, or further reflection on the evidence initially submitted." *Id.* at 73.

Cir. 1993).

In order to be entitled to modification, the Claimant must either establish a mistake in fact in the denial by Judge Solomon (as affirmed by the Board), or a material change in condition, that is, that he is now totally disabled by pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The Claimant, Theodore B. Barker, was born on October 11, 1918 (DX 2, Tr. 14). He married his wife, Alice Moore Barker, on April 19, 1948, and they reside together. The Claimant has no children who are under 18 or dependent upon him (DX 2).

Judge Solomon noted that the parties stipulated that the Claimant worked 37 years in coal mine employment (DX 48). I find the evidence supports that stipulation (DX 5) and thus I find Claimant worked 37 years in coal mine employment. At the hearing, Employer agreed that it is properly named as the Responsible Operator (Tr. 11).

Medical Evidence

The Administrative Law Judges who have previously considered Mr. Barker's claim, as well as the Board, have accurately summarized the medical evidence submitted in connection with the prior proceedings. In addition, the following new medical evidence is in the record.

X-ray Evidence[2]

Exhibit No.	*Date of X-ray*	*Reading Date*	*Physician/ Qualifications*	*Impression*
DX 54, 55	11-12-01	04-29-02	Alexander/B, BCR	2/3 q, s, Category A opacities
DX 54, 55	11-12-01	04-11-02	Ahmed/B, BCR	3/2 q, r, Category A opacities

[2] B-B reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

Exhibit No.	*Date of X-ray*	*Reading Date*	*Physician/ Qualifications*	*Impression*
EX 1	11-12-01	09-11-02	Wheeler/B, BCR	0/1 q, s, mass in the right mid and upper lung, probably tuberculosis
EX 1	11-12-01	09-11-02	Scott/B, BCR	1/1 t, u, bilateral primarily peripheral and linear infiltrates and/or fibrosis, probably tuberculosis
EX 1	11-12-01	09-11-02	Scatarige/B, BCR	1/0 r, q, 3x6 centimeter mass, right upper lung, and/or confluent infiltrate, check for tuberculosis or cancer. Multiple small nodules both lungs, probably tuberculosis, less likely, pneumoconiosis.
CX 1	10-10-02	11-15-02	Alexander/B, BCR	2/3 q, r, Complicated pneumoconiosis, right upper lung and right mid-lung.
EX 5	10-10-02	01-21-03	Wheeler/B, BCR	0/1 q, s, 8x3 centimeter mass, probably tuberculosis, also few small calcified granulomata possible tuberculosis, partly healed, recommend CT scan
EX 5	10-10-02	01-22-03	Scott/B, BCR	No pneumoconiosis, right infiltrate with possible ill defined 4 centimeter mass right upper lung, tuberculosis, marked asymmetry of involvement makes silicosis/coal workers' pneumoconiosis highly unlikely
EX 5	10-10-02	01-22-03	Scatarige/ B,BCR	No pneumoconiosis, 3.5 centimeter mass right upper lung, small nodules in peripheral portions both upper lobes, right greater than left, favor tuberculosis, advise CT scan. Few calcified granulomata in both lungs, doubt coal workers' pneumoconiosis/silicosis

CT Lung Scans

The Claimant underwent a CT lung scan in October 10, 2002. Dr. Michael Alexander,

who examined these films, and prepared a report dated November 15, 2002, found a background of small rounded opacities bilaterally, consistent with coal workers' pneumoconiosis. He also reported areas of coalescence of the small opacities, and multiple large opacities in the right lung. All of the large opacities contained internal areas of calcification, and changes of conglomerate fibrotic masses of complicated coal workers' pneumoconiosis, which excluded a malignant process. Dr. Alexander concluded that the CT lung scan showed Category B complicated coal workers' pneumoconiosis (CX 5).

Dr. Wheeler read this same CT scan and prepared a report dated January 30, 2003. He found a 3 centimeter mass compatible with conglomerate tuberculosis or histoplasmosis. He also reported tiny calcified granulomata in the hilar and subcarinal nodes, and one in the left lateral lung. According to Dr. Wheeler, these findings are compatible with healed tuberculosis or histoplasmosis. In addition, he stated that the nodules and mass are granulomatous disease because the pattern is asymmetrical and peripheral, and the mass contains calcified granulomata (EX 5)

Dr. Scott read this CT scan and prepared a report dated January 30, 2003. He noted a 3 centimeter mass, several calcified granulomata, and a few nodules less than one centimeter in size. Dr. Scott felt that these changes were probably due to tuberculosis, which is at least partially healed. He also indicated that the fact that the granulomata were calcified made cancer unlikely, but he recommended follow-up. Dr. Scott concluded there was no evidence of silicosis or coal workers' pneumoconiosis (EX 5).

Dr. Scatarige also reviewed the October 10, 2002 CT scan, and issued a report dated January 30, 2003. He found no small central nodules to suggest silicosis or coal workers' pneumoconiosis; a 2.7 x 2.8 centimeter mass in the right upper lung, possible organizing pneumonia, neoplasm or granulomatous disease; scattered calcified right hilar, subcarinal nodes of normal size; a 1 centimeter non-calcified nodule in the right lower lung; an 8 mm. possible calcified nodule in the left lower lung; scattered sub-centimeter sub-pleural nodules, and focal fibrosis in both lower lobes; many bilateral calcified granulomata; and a few sub-pleural bullae (EX 5).

Medical Opinion Evidence

Stone Mountain Health Services

A report on a tuberculosis test taken on May 30, 2002 was negative, showing no swelling, redness or induration (DX 54, 55).

Dr. J. Smiddy

Dr. Smiddy, the Claimant's treating physician, wrote a letter dated November 15, 2000, stating that the Claimant has repeatedly been diagnosed with disabling severe coal workers'

pneumoconiosis. Dr. Smiddy stated that this diagnosis was based on chest x-ray readings and the results of a guided biopsy by Dr. Adelson, which confirmed the presence of coal workers' pneumoconiosis (CX 1).

Treatment notes dated November 12, 2001 from Dr. Smiddy note a decrease in Claimant's breath sounds, and multiple B-reader findings of advanced pneumoconiosis dating back to 1982 in the files. Dr. Smiddy again referred to the biopsy, which confirmed the presence of coal workers' pneumoconiosis on March 11, 1999. He also stated that Claimant is totally disabled due to coal workers' pneumoconiosis, a fact that has been repeatedly documented over 20 years of records and treatment history. Dr. Smiddy diagnosed significant, dramatic, and severe coal workers' pneumoconiosis with progressive massive fibrosis and extensive old scarring, which has caused extensive changes over time. He noted that he has prescribed inhalers, which improve Claimant's performance somewhat. He also referred to additional pulmonary function study and blood gas study tests, but they were not included with the report (CX 3).

On May 8, 2002, Dr. Smiddy again reported that the Claimant has known pneumoconiosis to a significant degree. He noted decreased breath sounds on physical examination, and diagnosed bronchitis and coal workers' pneumoconiosis. He stated Claimant is totally disabled by coal workers' pneumoconiosis (CX 4).

Dr. A. Dahhan

Dr. A. Dahhan, a pulmonary specialist, reviewed Claimant's records, as well as earlier reports he prepared in this matter, and prepared a report dated January 3, 2003. He found no evidence of simple coal workers' pneumoconiosis, complicated coal workers' pneumoconiosis, or progressive massive fibrosis. He noted that the findings on pathological examination of the lung tissue by Dr. Hutchins failed to confirm the presence of complicated coal workers' pneumoconiosis. Dr. Dahhan felt that the lack of findings on clinical examination, including crackles and crepitation, supported his conclusion that there was no complicated pneumoconiosis. In addition, he relied on the fact that there was no physiological data of a restrictive ventilatory impairment, with reduction in the lung volumes and diffusion capacity and alteration in blood gas studies. Finally, while some x-ray readers found pneumoconiosis, the majority failed to confirm the presence of complicated pneumoconiosis or progressive massive fibrosis. From a respiratory standpoint, Dr. Dahhan felt that the Claimant has no evidence of a functional respiratory impairment and/or disability, based on the normal physiological parameters of his respiratory system on numerous occasions. Thus, from a respiratory standpoint, he retains the physiological capacity to do his previous coal mine employment or similar work (EX 2).

Dr. Gregory Fino

Dr. Fino, a board certified pulmonologist, reviewed the medical evidence, including his earlier reports in this matter, and prepared a report dated January 13, 2003. His earlier opinions, that there was no evidence of complicated pneumoconiosis, because there was no evidence of a

disabling respiratory or pulmonary impairment, did not change upon this review (EX 3).

Dr. L. Repsher

Dr. Repsher reviewed the medical records in this matter. He noted that Mr. Barker was an 84 year old man who worked in the coal mines for forty years, with his last job being a roof bolter. Mr. Barker smoked from 1930 to 1955. Dr. Repsher noted that the x-ray reading by Dr. Alexander of the November, 2001 x-ray film showed an opacity of 25 mm, which was less than the size of the opacity reported by Dr. Wheeler in February and August, 1999. He felt that this regression in size was not consistent with progressive massive fibrosis. He also noted that there was no objective evidence of impairment on the pulmonary function studies and blood gas studies. He concluded that Mr. Barker had simple coal workers' pneumoconiosis, but that it was not clinically significant, based on the regression in size from 1999 to 2001 on the x-rays, the normal pulmonary function study and blood gas study results, and the needle aspiration and core biopsies of the right upper lobe mass, which showed no specific diagnosis.[3] Dr. Repsher stated that from a pulmonary standpoint, Claimant is not totally disabled from coal mine employment. He concluded that the Claimant has simple coal workers' pneumoconiosis, chronic bronchitis related to his former cigarette smoking, normal pulmonary function, chronic degenerative disc disease, presumably lumbar spine, status post surgical repair of the right shoulder rotator cuff, granulomatous disease not ruled out since the negative tuberculosis test may be a false negative; and possible carcinoma of the right lung (EX 3).

Dr. Kirk Hippensteel

Dr. Hippensteel reviewed medical records, including his earlier reviews, and prepared a report dated January 15, 2003. He found that the additional medical evidence supported his earlier conclusions. Specifically, he felt that the preponderance of the evidence showed that the Claimant has developed simple coal workers' pneumoconiosis, with some coalescence of opacities on chest x-ray. But the physiologic findings do not support a diagnosis of complicated pneumoconiosis or any pulmonary impairment which would prevent the Claimant from performing his usual coal mine employment. According to Dr. Hippensteel, it is unusual to have complicated pneumoconiosis with no impairment. Therefore, he concluded that the Claimant had simple coal workers' pneumoconiosis, with no pulmonary impairment and no recent material change in functional status. He also felt that the pathologic data did not support a diagnosis of complicated coal workers' pneumoconiosis, because the tissue samples were too small (EX 3).

Dr. Hippensteel reviewed additional evidence, and prepared a report dated January 31, 2003. Again, he noted that the Claimant did not have a significant respiratory or pulmonary impairment, as the November 12, 2001 pulmonary function study results were normal. He

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[3] Dr. Repsher explained that while the histological evidence is probably consistent with simple coal workers' pneumoconiosis, a diagnosis of complicated pneumoconiosis cannot be made based on the small size of the specimen.

indicated that Dr. Smiddy's statement that Claimant is totally disabled is not supported by the results of the pulmonary function study. Again, he concluded that the Claimant has simple coal workers' pneumoconiosis, and not complicated pneumoconiosis, because a rapid change is not likely due to coal workers' pneumoconiosis, the pulmonary function study results were normal, and the calcifications seen on chest x-ray suggest granulomatous disease, which is a more localized condition that does not affect lung function. Dr. Hippensteel noted that a biopsy was negative for cancer (EX 4).

DISCUSSION

Twenty C.F.R. Section 727.203 (c) provides:

> Except as is otherwise provided in this section, the provisions of part 718 of this subchapter as amended from time to time, shall also be applicable to the adjudication of claims under this section.

Subsection (d) also provides that if eligibility is not established under Section 727.203, it may be established under Part 718. Section 718.304 provides for an irrebuttable presumption of total disability due to pneumoconiosis if a claimant suffers from a chronic dust disease of the lung which (a) when diagnosed by x-ray yields one or more large opacities greater than one centimeter in diameter, and would be classified as Category A, B, or C; (b) when diagnosed by biopsy or autopsy yields massive lesions in the lung; or (c) when diagnosed by means other than those specified in (a) or (b) would be a condition which could reasonably be expected to yield the results described in (a) or (b). If I find that the Claimant has established the existence of complicated pneumoconiosis, then he has successfully established all elements of entitlement. Thus, I will consider this issue first.

The decision of the Fourth Circuit in *Eastern Associated Coal Corporation v. Director, OWCP, [Scarbro],* 220 F.3d 250 (July 12, 2000), is very helpful in providing guidance in this particular case. In that case, the ALJ determined that x-ray and autopsy evidence were sufficient to invoke the presumption under 20 C.F.R. § 718.304(c). The Court discussed the three different ways set forth in the statute to establish the existence of statutory complicated pneumoconiosis in order to invoke the irrebuttable presumption, and noted that in applying the standards set forth in each prong,

> [O]ne must perform equivalency determinations to make certain that regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption.

Id. at 255, 256, *citing Double B Mining, Inc., v. Blankenship,* 177 F.3d 240, 243 (4th Cir. 1999). Additionally, the Court stated:

> "[B]ecause prong (A) sets out an entirely objective scientific standard" –i.e. an opacity on

> an x-ray greater than one centimeter –x-ray evidence provides the benchmark for determining what under prong (B) is a "massive lesion" and what under prong (C) is an equivalent diagnostic result reached by other means.

Id. at 256, *citing Double B Mining* at 243.

Although the Court acknowledged that a finding of statutory complicated pneumoconiosis may be based on evidence presented under a single prong, the Court also noted that the Administrative Law Judge must review the evidence under each prong for which relevant evidence is presented, to determine if complicated pneumoconiosis is present. The Court stated that:

> Evidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict. Yet, "a single piece of relevant evidence," *Lester [Lester v. Director, OWCP],* 993 F.2d at 1145, can support an ALJ's finding that the irrebuttable presumption was successfully invoked if that piece of evidence outweighs conflicting evidence in the record.

Id.

As the Court noted, even if there is some x-ray evidence that indicates that there are opacities that would satisfy the requirements of prong (A), if there is other x-ray evidence available, or other evidence relevant to an analysis under prongs (B) or (C), then all of the evidence must be considered to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray. The Court stated:

> Of course, if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force **only if other evidence affirmatively shows** that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader.

Id. (emphasis added).

The Fourth Circuit discussed the statutory definition of "complicated pneumoconiosis," noting that it is not congruent with a medical or pathological condition. The Court noted that the statute creating the irrebuttable presumption of causation does not refer to the condition as "complicated pneumoconiosis," or to a medical condition that doctors have independently called complicated pneumoconiosis. As the Court stated

> [T]he presumption under § 921(c)(3) is triggered by a congressionally defined condition,

> for which the statute gives no name but which, if found to be present, creates an irrebuttable presumption that disability or death was caused by pneumoconiosis. . . . In short, the statute betrays no intent to incorporate a purely medical definition.

Eastern Associated Coal Corporation,250 F.3d at 257.

Thus, if the Claimant meets the congressionally defined condition, that is, if he establishes that he has a condition that manifests itself on x-rays with opacities greater than one centimeter, he is entitled to the irrebuttable presumption of total disability due to pneumoconiosis, unless there is affirmative evidence under prong A, B, or C that persuasively establishes either that these opacities do not exist, or that they are the result of a disease process unrelated to his exposure to coal mine dust.

Evidence Under Prong A

The newly submitted medical evidence includes nine interpretations of two x-rays performed since the most recent denial. The first x-ray, performed on November 12, 2001, was interpreted by Dr. Alexander and Dr. Ahmed, both dually qualified physicians, as showing pneumoconiosis, as well as Category A opacities. Dr. Wheeler, Dr. Scott, and Dr. Scatarige, also dually qualified physicians, reviewed this x-ray as well. Dr. Wheeler found it to be negative for pneumoconiosis, but noted a mass in the right mid and upper lung, which he felt was probably tuberculosis. Dr. Scott found pneumoconiosis, as well as peripheral and lineal infiltrates and/or fibrosis, which he felt was probably due to tuberculosis. Dr. Scatarige found pneumoconiosis, as well as a 3 X 6 cm. mass in the right lung, which he felt could be tuberculosis or cancer.

The most recent x-ray, performed on October 10, 2002, was also interpreted by Dr. Alexander as showing pneumoconiosis, as well as Category A opacities. Again, Dr. Wheeler found no pneumoconiosis, but noted an 8 X 3 cm. mass, which he felt was probably tuberculosis. Dr. Scott found no pneumoconiosis, but also noted a possible ill-defined 4 centimeter mass in the right upper lung, which he felt was tuberculosis. Dr. Scatarige found no pneumoconiosis, but noted a 3.5 cm. mass in the right upper lung, which he felt "favored" tuberculosis.

Thus, in this case, there is x-ray evidence that there are opacities that would satisfy the requirements of prong (A), in the form of the interpretations by Dr. Alexander and Dr. Ahmed, with findings of Category A opacities. However, there is also other x-ray evidence available, as well as other evidence relevant to an analysis under prong (C), and thus all of the evidence must be considered to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray.[4]

I note that all of the interpreters who reviewed the two x-rays performed since Judge Solomon's denial, and who did not designate on the ILO form the presence of any large opacities,

[4] There is no new evidence in the record that falls under prong (B).

did nevertheless indicate the presence of a mass in the Claimant's lungs. It is worth noting that the ILO form used by these interpreters defines Category A, B, and C opacities in terms of the dimensions of these opacities. Thus, it requires that an opacity be designated as Category A, B, or C **solely** on the basis of the size of the opacity. While Dr. Dr. Wheeler, Dr. Scott, and Dr. Scatarige clearly found densities that satisfy these definitions, they did not so designate them on the ILO forms. The fact that these physicians did not attempt to properly classify these findings casts doubt on the reliability of their opinions. Certainly, they are not affirmative evidence that the opacities are not there; if anything, they support a conclusion that they are.[5]

Dr. Hippensteel, who reviewed the medical evidence, conceded that the Claimant has coal workers' pneumoconiosis, with some coalescence of opacities on x-ray. But he determined that he does not have complicated pneumoconiosis, based, depending on which report one looks at, on the absence of pulmonary impairment, the "rapid" change in the x-rays, and the calcifications in the coalescence, suggesting granulomatous disease. It is my conclusion that Dr. Hippensteel equates a finding of a "large opacity" with a clinical diagnosis of complicated pneumoconiosis; in other words, he does not believe that a miner satisfies the criteria for "large opacity" unless he has a medical diagnosis of complicated pneumoconiosis. But in order to meet the statutory presumption, it is not necessary for a miner to demonstrate that he has any impairment, or any "clinically significant" evidence of complicated pneumoconiosis. Nothing in Dr. Hippensteel's reports suggests that there are no opacities that meet the statutory criteria on the Claimant's x-rays, and indeed he noted coalescence of opacities on x-ray. But because the Claimant did not demonstrate functional impairment, Dr. Hippensteel concluded that it was not a "large opacity," in other words, that it was not due to complicated pneumoconiosis.

I find that the interpretations of Dr. Wheeler, Dr. Scott, Dr. Scatarige, and Dr. Hippensteel are not affirmative evidence that the Claimant does not have Category A opacities as reflected by x-ray, or that these opacities are caused by another disease process I find that the x-ray evidence establishes that the Claimant has a disease process that shows up on his x-rays, in the form of pneumoconiosis which manifests itself in the form of Category A opacities, as found by Dr. Ahmed and Dr. Alexander. I am not persuaded otherwise by the interpretations of Dr. Wheeler, Dr. Scott, Dr. Scatarige, and Dr. Hippensteel; I find their conclusions to be equivocal, and especially in light of the fact that there is not any evidence in the file to establish that the Claimant has had tuberculosis or another disease process that could be responsible for these findings, not affirmative evidence that the opacities are not there, or are not what they seem to be. While I acknowledge the impressive array of credentials possessed by those physicians who have not noted the presence of Category A opacities on x-ray, I find that their opinions do not affirmatively outweigh the findings of Category A opacities by the well-qualified physicians who noted the presence of such opacities. As the Fourth Circuit has noted, even a single piece of evidence can invoke the presumption under Section 718.304, if it outweighs conflicting evidence in the record. *Eastern Associated Coal Corporation, supra,* at 256.

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[5] As discussed *infra*, the Fourth Circuit has held that a finding of complicated pneumoconiosis is not synonymous with a medical diagnosis of complicated pneumoconiosis.

Evidence Under Prong (C)

There is also new evidence in the record that is relevant to an analysis under prong (C), in the form of CT scan interpretations, as set out above. Dr. Alexander found areas of coalescence of small opacities, as well as multiple large opacities with changes of conglomerate fibrosis. He felt that this scan showed Category B opacities. In contrast, Dr. Wheeler, Dr. Scott, and Dr. Scatarige also noted the presence of a mass; Dr. Wheeler felt it was tuberculosis or histoplasmosis, Dr. Scott felt the mass was "probably" due to tuberculosis, and Dr. Scatarige felt it was pneumonia, neoplasm, or a granulomatous disease.

In the absence of any medical evidence in the record that the Claimant contracted tuberculosis, or that he had cancer, or pneumonia,[6] I find that the interpretations by Dr. Wheeler, Dr. Scott, and Dr. Scatarige, which do not provide a diagnosis, but merely speculate about the disease processes that could be responsible for the findings on the Claimant's CT scan, do not provide affirmative evidence that there are no opacities on the Claimant's x-ray, or that they are due to a disease process other than complicated pneumoconiosis.

I note that under the statutory scheme as discussed by the Court in *Eastern Associated Coal Corporation, supra,* the presumption does not turn on a medical definition, but is satisfied by evidence that meets the definitions in the statute, regardless of the presence or absence of a medical diagnosis of complicated pneumoconiosis. Thus, it is not necessary that the Claimant be diagnosed with complicated pneumoconiosis; the statutory presumption is triggered by findings of Category A, B, or C opacities, in the absence of affirmative evidence that they are not there, or are due to another disease process.

I find that these opinions are not affirmative evidence that the opacities shows on the Claimant's x-rays are not what they seem to be, that is, that they are due to an intervening pathology.

Other Evidence

The remaining evidence is not relevant to an analysis under prong (C), which provides for consideration of equivalent diagnostic results reached by other means. Thus, although Dr. Dahhan reviewed the Claimant's medical records, he did not independently review the x-rays or CT scan, but relied on the interpretations by other physicians. I also note that Dr. Dahhan based his conclusion that the Claimant does not have complicated pneumoconiosis on the lack of clinical or objective data of impairment. However, in order to establish invocation of the presumption under Section 718.304, a claimant need not establish that he has any degree of functional impairment or disability. As the Fourth Circuit has noted, the presumption is satisfied by evidence that meets the definitions in the statute, regardless of the presence or absence of a clinical finding of complicated pneumoconiosis.

[6] Indeed, a recent tuberculosis test was negative, and several physicians ruled out cancer.

Similarly, Dr. Fino, who reviewed the interpretations by others, determined that the Claimant does not have complicated pneumoconiosis, because there is no evidence of a disabling respiratory or pulmonary impairment. Dr. Repsher also concluded that the Claimant does not have complicated pneumoconiosis, because there is no objective evidence of impairment on pulmonary function and arterial blood gas studies. Finally, Dr. Hippensteel concluded that the medical records supported a conclusion that the Claimant has simple pneumoconiosis, and that there is some coalescence of opacities. But since there was no evidence of pulmonary impairment, he did not feel that a diagnosis of complicated pneumoconiosis was warranted.

For the reasons discussed above, I find that the x-ray readings by Dr. Ahmed and Dr. Alexander are sufficient to invoke the irrebuttable presumption of total disability pursuant to § 718.304. I find that their probative force is not outweighed either by the findings on other x-ray reports, or by the findings on CT scans. Thus, the Claimant is entitled to the statutory presumption of total disability. I therefore find that the Claimant has established by a preponderance of the newly submitted medical evidence that he suffers from pneumoconiosis that arose out of his coal mine employment, and that he is totally disabled due to his pneumoconiosis. The Claimant is therefore entitled to consideration of his claim on the merits.

Merits of the Claim

In addition to the newly submitted medical evidence, the record includes thirty nine interpretations of nineteen x-rays performed between June 1978 and June 2000. The thirteen readings of the ten x-rays performed between June 1978 and September 1991 are unanimously positive for the existence of pneumoconiosis, but make no notations consistent with complicated pneumoconiosis. The next x-ray was performed almost eight years later, on February 20, 1999, and it was interpreted by Dr. Westerfield, a dually qualified physician, who found pneumoconiosis and a Category A opacity. Dr. Wheeler, Dr. Scott, and Dr. Kim, all dually qualified, made no findings of pneumoconiosis or Category A, B, or C opacities. However, Dr. Wheeler noted a 3-4 cm. infiltrate, fibrosis, or mass in the right upper lung, which he felt was compatible with tuberculosis more likely than a tumor. Dr. Fino, a B reader, found pneumoconiosis, noting that there was coalescence in the right upper zone, although he did not classify it as Category A, B, or C opacities.

An x-ray performed on March 11, 1999 was read as negative by Dr. Wheeler, Dr. Scott, and Dr. Kim, and as positive by Dr. Fino, who again noted coalescence in the right upper zone. Dr. Wheeler noted a conglomerate mass in the right upper lung, which he felt was more likely to be tuberculosis than pneumoconiosis. Dr. Wheeler also reviewed a chest CT scan of the same date, noting a 3 cm. mass in the right mid lung, which he felt was compatible with inflammatory disease or cancer.

The next x-ray, performed on August 19, 1999, was interpreted by Dr. Paranthaman, a B reader, and Dr. McCloud, who is dually qualified, as positive, with Category B opacities. Dr. Sargent, who is dually qualified, interpreted it as positive. Again, Dr. Wheeler, Dr. Scott, and Dr. Kim found this x-ray to be negative. Dr. Wheeler noted a 3 X 5 cm mass or infiltrate in the right

upper lung, which he felt was "probably" tuberculosis rather than a large opacity of pneumoconiosis. Dr. Scott also noted peripheral nodular infiltrates in the upper lungs, compatible with tuberculosis or unknown activity.

An x-ray performed on September 28, 1999 was interpreted as negative by Dr. Wheeler, Dr. Scott, and Dr. Kim; Dr. Fino found it positive, again with coalescence in the right upper zone. Dr. Wheeler again noted the 3 cm. mass or fibrosis in the right mid lung, that he felt was compatible with an inflammatory disease such as tuberculosis, more likely than tumor. Dr. Wheeler, Dr. Scott, and Dr. Kim also found the x-ray of March 23, 2000 to be negative, while Dr. Dahhan found it to be positive. Dr. Wheeler again noted a moderate ill defined infiltrate or fibrosis in the right mid lung; Dr. Scott noted bilateral mid lung infiltrates and/or fibrosis, probably due to granulomatous disease or unknown activity. Dr. Kim noted linear or nodular infiltrate in the periphery of the upper lung and the right mid lung, which was "probably" due to a granulomatous process of unknown activity.

Finally, Dr. Wheeler, Dr. Scott, and Dr. Kim found the June 13, 2000 x-ray to be negative. Dr. Wheeler noted a small ill defined mass or fibrosis in the right mid lung, compatible with inflammatory disease or possibly cancer.

Again, given the abundant evidence that there is a mass in the Claimant's right lung, I do not find the opinions by Dr. Wheeler, Dr. Scott, Dr. Kim, and Dr. Fino, who all acknowledge the presence of such a mass, but speculate as to its cause, to be affirmative evidence that the Claimant does not have Category A or B opacities on his x-ray, or that they are due to another disease process. Considering the newly submitted evidence with the old, I find that the Claimant has established by the preponderance of the evidence that he is entitled to the irrebuttable presumption of total disability pursuant to Section 718.304.

Many of the medical opinion reports in the record predate the first finding of Category A opacities by Dr. Westerfield in February 1999, and thus they do not address that issue; nor does anything in these reports provide affirmative evidence either that there are no large opacities on the Claimant's x-rays, or that the large opacities are due to a disease process other than pneumoconiosis.

Subsequently, Dr. Fino, Dr. Dahhan, Dr. Wheeler, Dr. Hippensteel, and Dr. Repsher submitted opinions based on their review of the medical evidence, concluding that, although there was evidence of simple pneumoconiosis, the Claimant did not have complicated pneumoconiosis. Each of these physicians, however, relied on the fact that the Claimant did not have sufficient evidence of pulmonary impairment to justify a diagnosis of complicated pneumoconiosis. In other words, they relied on a strictly medical definition of complicated pneumoconiosis. Each of them acknowledged the presence of a process in the Claimant's right lung, whether infiltrate, mass, fibrosis, or coalescence, and speculated as to the etiology of this process. Again, in the absence of any evidence that the Claimant has ever suffered from or been exposed to tuberculosis or any other inflammatory disease, I find these opinions to be speculative, and certainly not affirmative evidence that there are no opacities on the Claimant's x-rays, or that they are due to a disease

process other than pneumoconiosis.

There is biopsy evidence in the record, but it does not satisfy the requirements of Prong B, which requires biopsy or autopsy evidence of massive lesions in the lung. Thus, Dr. Adelson reviewed tissue slides from a biopsy and fine needle aspiration performed on March 11, 1999, finding marked fibrosis with numerous fibroblasts, and extensive anthracotic pigment deposition. There were also numerous small birefringent particles compatible with silica. He did not identify any malignancy. Dr. Adelson noted that in order to make a definitive diagnosis of complicated pneumoconiosis, it was necessary to examine a significant sample of a lung, both macroscopically and microscopically. He did feel that the histologic findings would be compatible with complicated pneumoconiosis or progressive massive fibrosis (DX 8).

Dr. Hutchins also reviewed this tissue slide, finding a large amount of coal dust pigment with associated birefringent silicate-type particles. However, he stated that it was not possible to determine the nature of any pneumoconiosis based on the size of the specimen. He found no evidence of malignancy (DX 41).

This is consistent with the conclusions by Dr. Repsher. However, while the tissue sample was not large enough to definitively diagnose progressive massive fibrosis, or complicated pneumoconiosis, neither does the examination of that tissue affirmatively establish that the Claimant does not have complicated pneumoconiosis, as defined in the regulations.

CONCLUSION

The Claimant has established a material change in conditions, that is, that he is totally disabled due to pneumoconiosis, pursuant to Section 718.304. Reviewing all of the medical evidence of record, both old and new, I find that the Claimant has established by a preponderance of the evidence that he is entitled to the statutory presumption of total disability due to pneumoconiosis, as set out in Section 718.304, and thus he is entitled to benefits under the Act.

ORDER

It is ordered that the claim of Theodore B. Barker for benefits under the Black Lung Benefits Act is hereby GRANTED.

It is further ordered that the Carrier, Acordia Employer's Service, shall pay to the Claimant all benefits to which he is entitled under the Act commencing in February 1999, which is the date of the first x-ray that was interpreted as showing complicated pneumoconiosis.

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LINDA S. CHAPMAN
Administrative Law Judge

ATTORNEY'S FEES

An application by Claimant's attorney for approval of a fee has not been received. Thirty days is hereby allowed to Claimant's counsel for submission of such an application. A service sheet showing that service has been made upon all the parties, including the claimant, must accompany the application. The parties have ten days following receipt of any such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this decision, by filing a Notice of Appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. *A copy of a Notice of Appeal must also be served on Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, NW, Room N-2117, Washington, D.C. 20210.*